# HARDSHIP CONSIDERATION (Calendar Year 2021)

**Personal Information** *(Please Print)*

CID #: _____

Client Name: _____
*(First)* *(MI)* *(Last)*

Address: _____ Ph. #: _____
*(Street)* *(City)* *(State)* *(Zip)*

Parent/Guardian or Representative (if applicable):_____

Address (if different from above): _____

☐ **YES** ☐ **NO** Will the client be receiving **Substance Use Disorder Treatment Services**?
☐ **YES** ☐ **NO** Will the client be receiving **Gambling Services**?

**Check type of SUD and/or gambling service:** ☐ 0.5 Early Intervention ☐ 1.0 Outpatient
☐ 2.1 IOP ☐ 3.1 Residential ☐ 3.2 Detoxification ☐ 3.7 Inpatient ☐ Adult EBP ☐ MRT

**Check type of MH service:** ☐ CARE ☐ CYF ☐ IMPACT ☐ MH Outpatient (Non-SMI/Non-SED)

☐ **YES** ☐ **NO** Will **CYF or CARE** services exceed two or more units per month? Please indicate the number of units per month and the duration for which services will continue.

_____

**Imminent Risk or Emergency:**

☐ **YES** ☐ **NO** Is there an imminent risk of hospitalization, residential placement, or out of home placement? Is there potential for involvement/increased involvement with other systems (e.g., law enforcement, CPS, UJS, DOC)? Please explain.

_____

_____

☐ **YES** ☐ **NO** Is there an emergency (e.g., suicidal, acutely psychotic, demonstrates potential relapse, or co-occurring disorder) that can be treated in a community setting? Please explain.

_____

_____

I hereby attest that this information is true and correct.

_____

Signature (Behavioral Health Representative) Date